

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**=61-008811**

AMENDED

Registration District No. 149 Primary Registration District No. 1001 Registrar's No. 1352 STATE FILE NUMBER

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF **Frank Paul Laurence** Medical Certification

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY <b>Jackson</b>                       |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Kansas City</b>  |   | Length of stay in 1b<br><b>64 yrs</b>   | c. CITY OR TOWN <b>Kansas, City, Mo.</b> Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                      |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Linwood Blvd N. Home</b>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>1900 E. Linwood</b> Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MAUDE</b> Middle <b>ELIZABETH</b> Last <b>HALL</b>   |   |   | 4. DATE OF DEATH<br>Month <b>3</b> Day <b>15</b> Year <b>61</b>  |
| 5. SEX<br><b>Fe</b>  | 6. COLOR OR RACE<br><b>Wh</b>   | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9-30-92</b>   |
| 9. AGE (last birthday)<br><b>68</b>  |   | IF UNDER 1 YEAR<br>Months _____ Days _____  | IF UNDER 24 HR<br>Hours _____ Min. _____   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  | 11. BIRTHPLACE (City and state or country)<br><b>Wyandotte County, Ks</b>  |
| 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>  |   | 13a. FATHER'S NAME<br><b>Arthur Cobleigh</b>  |  |
| 13b. MOTHER'S MAIDEN NAME<br><b>Alice E. Lansdown</b>  |   | 14. NAME OF HUSBAND OR WIFE<br><b>Henry I. Hall</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>XX</b>  |  |
| 17. INFORMANT<br><b>Margaret Williamson, 124 S. Van Brunt</b>  |   | Address <b>KC Mo</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis</b><br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>8 years</b>   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Hour _____ a.m. _____ p.m.  | Month, Day, Year _____  |   |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 20f. CITY, TOWN, OR LOCATION  | COUNTY STATE   |
| 21. I attended the deceased from <b>2-25-55</b> to <b>3-15-61</b> and last saw her alive on <b>3-15-61</b><br>Death occurred at <b>7:00 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.  |   |   |  |
| 22a. SIGNATURE (Degree or title)<br><b>Frank Paul Laurence M.D.</b>  |   | 22b. ADDRESS<br><b>428 S. White Ave</b>   | 22c. DATE SIGNED<br><b>3-15-61</b>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE<br><b>3-18-61</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Washington Cem.</b>  | 23d. LOCATION (City, town, or county) (State)<br><b>Kansas City Mo.</b>  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>WAGNER FUNERAL HOME, K.C. Mo.</b>   |   | 25. DATE RECD. BY LOCAL REG.<br><b>3-16-61</b>  | 26. REGISTRAR'S SIGNATURE<br><b>Ruth Long</b>  |

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Alvin R. Hainscheld

Licensed Embalmer No. 4159

P. O. Address K. C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.